Prior Authorization Request for Additional Services

Client Last Name: _____ Client First Name: _____

Medicaid Number: _____ Date of Birth: _____

Health Condition/Risk: _____

Describe why additional services are needed:

Prior authorization request for:

_____**# Comprehensive visit**s _____**# Face-to-face follow visits** _____**# Telephone follow visits**

Case manager signature Date Public Health Region

Case manager name (please print) Case management provider name TPI number

( ) - ( ) -

Provider phone number Provider fax number Provider e-mail

Reminder: This form must be accompanied by a copy of the intake, family needs assessment, service plan, service plan addendums, follow-up notes and any other documentation that supports the request.

Note: Prior authorization is a condition of reimbursement for all services provided after September 1, 2003. Prior authorization is not a guarantee of payment.

TDH Central Office Use Only		
Received via: ☐ FAX ☐ MAIL	Date received by TDH:	
Reviewed by:	Date:	
Authorization number for dates of service prior to 10-16-2003:		
Comprehensive visits (9100x):	Face-to-face follow-up visits (9101X):	Telephone follow-up visits (9102X):
Date authorization effective:	Date Authorization expires: **October 16, 2003**	
Authorization number for dates of service after 10-16-2003:		
Comprehensive visits (G9012 U2 +U5):	Face-to-face follow-up visits (G9012 TS + U5)	Telephone follow-up visits (G9012 TS):
Date authorization effective: **October 16, 2003**	Date Authorization expires:	
If denied, reason for denial ☐ Required documentation not received ☐ Medicaid not in effect ☐ No need identified ☐ Documentation on request does not support client meets eligibility as defined in rule ☐ Another provider is involved. Services must be coordinated with family and		
Date request returned to provider	Staff	